2011 Procedures Adult Criteria

Hysteroscopy, Operative (Custom) - UDOH[1*RIN, 2]

Created based on InterQual Subset: Hysteroscopy, Operative

Version: InterQual® 2010

CLIENT:	Name	D.O.B.	ID#	GROUP#
CPT/ICD9:	Code	Facility	Service Date	
PROVIDER:	Name		ID#	Phone#
	Signature		Date	

ICD-9-CM: 68.12, 68.16, 68.21, 68.22, 68.23, 68.29, 97.71

INDICATIONS (choose one and see below)

- ☐ 100 Lysis of endometrial synechiae
- ☐ 200 Uterine polyp
- ☐ 300 Resection of submucous fibroids in premenopausal woman
- ☐ 400 Endometrial ablation for dysfunctional uterine bleeding in premenopausal woman
- ☐ 500 Uterine septum division
- ☐ Indication Not Listed (Provide clinical justification below)

☐ 100 Lysis of endometrial synechiae **[One]**[3]
- ☐ 110 Synechiae **[Both]**
  - ☐ 111 Diagnosed by Ultrasound
  - ☐ 112 Clinical symptoms of menstrual disturbance

☐ 200 Uterine polyp **[Both]**[4]
- ☐ 210 Sx/findings **[One]**[5]
  - ☐ 211 Recurrent vaginal spotting
  - ☐ 212 Abnormal vaginal bleeding
  - ☐ 213 Abdominal/pelvic pain/cramps
  - ☐ 214 Polyp ≥ 1 cm
- ☐ 220 Diagnosed **[One]**
  - ☐ 221 By US
  - ☐ 222 By endometrial Bx

☐ 300 Resection of submucous fibroids in premenopausal woman **[Both]**[6*RIN, 7, 8]
- ☐ 310 Diagnosed by US
- ☐ 320 Findings **[One]**

- ☐ 321 Spontaneous abortion by Hx **[Both]**[9]
  - ☐ -1 ≥ 2 episodes
  - ☐ -2 Hx & PE normal except for fibroids
- ☐ 322 Abnormal bleeding ≥ 3 cycles **[All]**[10, 11, 12]
  - ☐ -1 Vagina and cervix normal by PE
  - ☐ -2 PAP smear normal w/in last yr[13]
  - ☐ -3 Thyroid disease excluded by PE/testing[14]
  - ☐ -4 Pregnancy excluded **[One]**[15]
    - ☐ A) HCG negative[16]
    - ☐ B) Sterilization by Hx[17]
  - ☐ -5 Continued abnormal bleeding **[One]**
    - ☐ A) Interferes with ADLs[18]
    - ☐ B) Hct < 27%(0.27) / Hb < 9.0 g/dL(90 g/L) unresponsive to iron Rx > 12 wks[19]

☐ 400 Endometrial ablation for dysfunctional uterine bleeding in premenopausal woman **[All]**[20]
- ☐ 410 Heavy bleeding or Inter-menstrual bleeding ≥ 3 cycles[10, 11]
- ☐ 420 Vagina and cervix normal by PE
- ☐ 430 Thyroid disease excluded by PE/testing[14]
- ☐ 440 PAP smear normal w/in last yr[13]
- ☐ 450 Pregnancy excluded **[One]**[15]
  - ☐ 451 HCG negative[16]
  - ☐ 452 Sterilization by Hx[17]
- ☐ 460 Continued bleeding **after** Rx **[One]**[21]
  - ☐ 461 Age < 35 **[All]**
    - ☐ -1 Endometrial findings **[One]**
      - ☐ A) Patient with endometrial thickness by transvaginal ultrasound that is ≥5mm and currently taking tomoxifen
      - ☐ B) Patient not taking tomoxifen (Patients with endometrial thickness by transvaginal ultrasound that is <5mm)
      - ☐ C) Patient with endometrial thickness by transvaginal ultrasound that is ≥5mm, not currently taking tomoxifen **[One]**
        - ☐ 1) Endometrium normal w/in last year **[One]**
          - ☐ a) By endometrial Bx
          - ☐ b) By hysteroscopy with D & C
    - ☐ -2 Progestin/OCP trial **[One]**
      - ☐ A) Trial x3 consecutive cycles
      - ☐ B) Contraindicated[22]
    - ☐ -3 Findings **[One]**
      - ☐ A) Interferes with ADLs[18]

- ☐ B) Hct < 27%(0.27) / Hb < 9.0 g/dL(90 g/L) unresponsive to iron Rx > 12 wks[19]

☐ 462 Age ≥ 35 **[All]**

- ☐ -1 Endometrium normal w/in last year **[One]**[23]
  - ☐ A) By endometrial Bx
  - ☐ B) By hysteroscopy with D & C
- ☐ -2 Progestin/OCP trial **[One]**
  - ☐ A) Trial x3 consecutive cycles
  - ☐ B) Contraindicated[22]
- ☐ -3 Findings **[One]**
  - ☐ A) Interferes with ADLs[18]
  - ☐ B) Hct < 27%(0.27) / Hb < 9.0 g/dL(90 g/L) unresponsive to iron Rx > 12 wks[19]

☐ 500 Uterine septum division **[Both]**[24]

- ☐ 510 No bicornuate uterus by laparoscopy/US/MRI[25, 26]
- ☐ 520 History of pregnancy complications such as preterm delivery, late abortion, or recurrent pregnancy loss.

Notes

(1)-RIN:

Operative hysteroscopy allows the surgeon to obtain specimens and perform a variety of procedures. These criteria apply to hysteroscopy performed in the operating room; office hysteroscopy is limited to diagnostic procedures and endometrial biopsy.

(2)

Hysteroscopy allows direct visualization of the endocervical canal, uterine cavity, and tubal ostia without cutting through the uterine wall for access. Complications of the procedure include uterine perforation, air emboli, bleeding, fluid overload, and cervical trauma. Hysteroscopy is contraindicated in the presence of infection or uterine cancer (ACOG Technology Assessment. Obstet Gynecol 2005; 106(2): 439-442).

(3)

Synechiae are endometrial adhesions which can, in some cases, lead to secondary amenorrhea (Asherman's syndrome) and are most often caused by a prior D & C or a previous pregnancy. Hysteroscopy is performed to confirm the diagnosis and for therapeutic lysis of adhesions (Propst and Hill, Semin Reprod Med 2000; 18(4): 341-350).

(4)

Polyps are detected frequently because of the widespread use of transvaginal US and sonohysterography (Goldstein et al., Am J Obstet Gynecol 2002; 186(4): 669-674). Simple polypectomy has been shown to result in high satisfaction rates (65%) in women presenting with pain and abnormal bleeding (Tjarks and Van Voorhis, Obstet Gynecol 2000; 96(6): 886-889).

(5)

The incidence of malignancy in polyps is low and, therefore, removal of asymptomatic polyps remains controversial. McKesson consultants feel that polypectomy should be reserved for symptomatic patients or for polyps ≥ 1 cm in size.

(6)-RIN:

These criteria cover hysteroscopy for symptomatic submucous fibroids in premenopausal women; symptomatic fibroids discovered in a postmenopausal woman require an evaluation to exclude malignancy. Hysterectomy is preferable in postmenopausal women.

(7)

Hysteroscopic myomectomy is the procedure of choice for treatment of submucous fibroids and may be offered as an alternative to hysterectomy in premenopausal women who wish to preserve childbearing capability (Batra et al., Obstet Gynecol Clin North Am 2004; 31(3): 669-685, xi).

(8)
Administration of a GnRH agonist for 8 to 12 weeks can reduce fibroid size and make the resection less extensive (Agency for Healthcare Research and Quality, AHRQ Publication No. 01-E051, January 2001; ACOG Practice Bulletin No. 16, May 2000; Shwayder, Obstet Gynecol Clin North Am 2000; 27(2): 219-234.).

(9)
Approximately 40% to 60% of women undergoing hysteroscopic myomectomy for either infertility or recurrent pregnancy loss subsequently deliver term infants (ACOG Practice Bulletin No. 16, May 2000).

(10)
Abnormal bleeding includes menorrhagia (heavy and prolonged menses) and menometrorrhagia (heavy and prolonged bleeding during and between menses).

(11)
Patients may present with bleeding between periods that is not necessarily heavy or prolonged.

(12)
Fibroids, even small ones, are associated with an increased risk of heavy and prolonged bleeding (Wegienka et al., Obstet Gynecol 2003; 101(3): 431-437). It is not necessarily the size of the fibroid that determines the need for treatment, but rather patient symptoms and fibroid location.

(13)
The American College of Obstetricians and Gynecologists (ACOG), the American Cancer Society (ACS), the National Cancer Institute, and the American Medical Association (AMA) recommend that all women have annual PAP testing for routine cervical screening within 3 years of the onset of sexual activity and no later than age 21. After the age of 30 and 3 consecutive normal smears, low-risk women (defined as having one lifetime sexual partner who has never had another sexual partner) may have screening performed less frequently at the discretion of the clinician and patient; screening should be performed at least every three years (Noller, Obstet Gynecol 2005; 106(2): 391-397; Smith et al., CA Cancer J Clin 2005; 55(1): 31-44; quiz 55-56; American College of Obstetricians and Gynecologists, Obstet Gynecol 2003; 102(2): 417-427; U.S. Preventive Services Task Force. AHRQ Publication No. 03-515A, January 2003). As part of comprehensive pre-procedure planning, however, a PAP smear should be documented within the last year; a normal PAP smear is essential to exclude cervical disease which, if present, may alter treatment.

(14)
Hypothyroidism or hyperthyroidism may cause a variety of menstrual irregularities (i.e., menorrhagia (heavy and prolonged menses), amenorrhea (no menses), or oligomenorrhea (scant menses)). Documentation to exclude a thyroid disorder as a cause of the bleeding may be performed at any time in the work-up of the patient and may be by the patient's PCP, gynecologist, or a specialist.

(15)
Pregnancy and related complications (e.g., ectopic pregnancy, incomplete abortion, inevitable abortion) must be excluded before performing this procedure.

(16)
Pregnancy testing can be by measurement of either a serum or urine HCG and may be documented in either the PCP's, gynecologist's, or surgeon's records.

(17)
The healthcare provider should document a history of sterilization (i.e., tubal ligation) without a subsequent pregnancy. This criteria does not include sterilization of a partner, nor does it cover alternate birth control methods (e.g., OCP use, IUD insertion).

(18)
Activities of daily living (ADLs) are frequently divided into those simple activities relating to basic self-care and those that involve more complex interactions with others and the environment (called instrumental activities of daily living or IADLs). This criterion includes both types of activity. Whether a condition is of sufficient severity to interfere with ADLs or IADLs is somewhat subjective. There should be an indication that symptoms impede the patient's ability to effectively work, shop, manage at home, care for family members, or tend to personal hygiene.

(19)
Ferrous sulfate is generally not well tolerated. Other iron preparations (e.g., ferrous gluconate, oral polysaccharide iron complex) are better tolerated and are more likely to ensure compliance with treatment.

(20)

The diagnosis of DUB is made by excluding pregnancy, medication use, systemic conditions, and genital tract pathology as the cause of the bleeding. Blood work and history can exclude coagulopathy, or hematologic or thyroid problems, while PE or US excludes structural problems such as fibroids (Albers et al., Am Fam Physician 2004; 69(8): 1915-1926).

(21)

Hysteroscopic endometrial resection or ablation, in which the whole thickness of the endometrium and some superficial myometrium is removed or destroyed, is performed for DUB as an alternative to hysterectomy (Obstet Gynecol 2007; 109(5): 1233-1248; Zupi et al., Am J Obstet Gynecol 2003; 188(1): 7-12). Approximately 89% of patients are satisfied with or benefited from the procedure at follow-up (Dickersin et al., Obstet Gynecol 2007; 110(6): 1279-1289; Perino et al., Fertil Steril 2004; 82(3): 731-734). Pretreatment with GnRH agonists or danazol causes thinning of the endometrium and can improve ablation success and short-term outcomes (Sowter et al., Cochrane Database Syst Rev 2002; (3): CD001124). Although short-term success rates are high following endometrial ablation, approximately 18% of women subsequently require hysterectomy for resolution of continued bleeding; most of the repeat operative procedures are performed within the first 2 years after the initial surgery (Marjoribanks et al., Cochrane Database Syst Rev 2006; (2): CD003855). Up to 31% of patients require reoperation when followed for 4 years (Dickersin et al., Obstet Gynecol 2007; 110(6): 1279-1289).

Non-hysteroscopic (second generation) techniques for ablating the endometrium (e.g., thermal balloon, cryoablation, microwave or electrode ablation) performed with local anesthesia have also been shown to be beneficial for the treatment of menorrhagia and are simpler and quicker to perform than hysteroscopic ablation (Lethaby et al., Cochrane Database Syst Rev 2005; (4): CD001501; Marjoribanks et al., Cochrane Database Syst Rev 2003; (2): CD003855; Pellicano et al., Am J Obstet Gynecol 2002; 187(3): 545-550). There is no significant difference in the need for additional surgery or hysterectomy when comparing hysteroscopic ablation to the second generation, non-hysteroscopic techniques (Obstet Gynecol 2007; 109(5): 1233-1248; Lethaby et al., Cochrane Database Syst Rev 2005; (4): CD001501).

The levonorgestrel-releasing intrauterine system has been shown to be as effective as ablation in reducing menstrual blood flow, and women report high satisfaction scores for both interventions. The intrauterine system is more cost-effective than either ablation or hysterectomy, however, for treating DUB (Busfield et al., BJOG 2006; 113(3): 257-263; Lethaby et al., Cochrane Database Syst Rev 2005; (4): CD002126; Hurskainen et al., JAMA 2004; 291(12): 1456-1463).

(22)-DEF:

Contraindications to Progestin/OCP's include:
-Smoking in patients ≥35 years old
-History of CVA or MI or multiple risk factors for coronary artery disease (older, smoker, HTN, DM)
-Moderate or severe HTN (baseline BP ≥160/100), should also avoid in patients who have more adequately controlled HTN as risks usually outweigh benefits.
-Diabetes with significant vascular disease
-Complicated valvular heart disease
-Thrombophilia or Thromboembolic disorder (history of DVT/PE)
-Major surgery with prolonged hospitalization
-Known or suspected pregnancy
-Undiagnosed vaginal bleeding
-Known or suspected breast cancer (or history of breast cancer)
-Markedly abnormal liver function, active viral hepatitis, malignant liver tumor
-Avoid in patients with symptomatic gall bladder disease current or treated
-Migraine with focal neurologic symptoms (flashing lights, loss of vision, weakness, slurred speach)
-Well-differentiated and early endometrial

(23)

Examination of the endometrium is necessary in women ≥ 35; there is a greater incidence of malignancy or endometrial hyperplasia in this age group (ACOG Practice Bulletin No. 14, Mar 2000).

(24)

Hysteroscopic visualization of the uterine septum alone is not adequate for diagnosis. Performing laparoscopy at the time of the hysteroscopy can provide direct confirmation of a Mullerian defect (Hickok, Am J Obstet Gynecol 2000; 182(6): 1414-1420).

(25)-DEF:

A bicornuate uterus forms from the incomplete fusion of the Mullerian ducts at the level of the fundus and results in 2 separate endometrial cavities and a single cervix.

(26)

A combination of diagnostic testing and imaging is generally necessary for making the diagnosis (Patton et al., Am J Obstet Gynecol 2004; 190(6): 1669-1675; discussion 1675-1678; Hickok, Am J Obstet Gynecol 2000; 182(6): 1414-1420). Differentiation of a septate uterus from a bicornuate anomaly is important, as the surgical interventions are very different.